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The Bristol Medico-Chirurgical Journal

"Scire est nescire, nisi id me Scire alius sciret."

SUMMER, 1944.

THE THIRTY-SECOND LONG FOX MEMORIAL LECTURE:

BY

PROFESSOR C. BRUCE PERRY, M.D., F.R.C.P.,

Professor of Medicine in the University of Bristol.

DELIVERED IN THE UNIVERSITY OF BRISTOL ON TUESDAY, 26th OCTOBER, 1943,

ON

THE SOCIAL ASPECTS OF ACUTE RHEUMATISM.

THE social aspects of medicine have received much attention during the past few years, and as you will know the University of Oxford, helped by the generosity of the Nuffield Trustees, has recently founded a Chair of Social Medicine. Social medicine is no new subject. What is new is the increasing realization of its great importance to practitioners and students of all branches of medicine. It is difficult to give a definition of social medicine which is acceptable to everyone. Perhaps one of the best is, that it is that branch of medicine which concerns itself with the social environment and heredity of man as they affect health both mental and physical. Some people consider that social medicine is merely another name for public health work and preventive medicine. However, if we

accept the definition of social medicine, which I have suggested, then preventive medicine is the executive counterpart of social medicine and may be defined as the putting into effect of measures designed to raise the general level of health of the community and to prevent disease. Whatever definition of Social Medicine is accepted it is clear that its study covers a wide field. As Sir Farquhar Buzzard (1943) said recently, "it might be said to embrace the whole art and science of Medicine, the main object of which is to ensure that every member of the community may play his or her part in its life to full capacity and without the handicaps arising from mental or physical ill-health." Dr. Long Fox was a physician with views and ideas far ahead of his time in realizing that medicine must concern itself with social matters, and for this reason I hope that he would have approved the subject which I have chosen for this lecture. When President of the British Medical Association in 1894, he gave his presidential address on "the Medical Man and the State." In this address he said: "the poor, the sick and the criminal are our daily study primarily for the relief of the individual, but with nobler and further reaching aims—namely, that poverty may be mitigated by more healthy surroundings; that sickness may be diminished by the education of the nation in the wiser laws of health." Perhaps I can best illustrate the different view points of curative and social medicine by an example recently used by Professor Henry Cohen (1943), in another connection. Suppose we are confronted by a young man of thirty who has developed paralysis of one side of the body. We examine him and decide that this paralysis is due to a clot in one of the arteries of the brain. However, in order to institute efficient treatment we must endeavour to discover the cause of the clot, and we find that this is due to disease of the artery caused by syphilis. At this point curative medicine is satisfied since the therapeutic indications are clear. Social medicine on the other hand asks why did this young man contract syphilis five years before. We do not know the complete answer to this question; it is obviously many-sided, and it does not require much imagination to envisage the story of poverty, poor housing, unattractive work and frustrated ambitions that may lie behind the final tragedy.

Acute rheumatism, the social aspects of which I wish to discuss to-night, is a disease which is very unfortunately named. Rheumatism suggests a condition of pain in or around a joint; yet acute rheumatism may run a fatal course with no joint pain of any sort. It is a disease which has different manifestations. First of all there is the arthritis or acute inflammation of joints from which the disease was named. Another manifestation is, strangely enough at first sight, Sydenham's chorea or St. Vitus's Dance. Why one patient should suffer from arthritis and another from St. Vitus's

Dance though both apparently are afflicted with the same disease is only one of the many baffling and intriguing mysteries of this condition. Dr. Long Fox by his researches into the nature of St. Vitus's Dance helped to lay one of the stepping stones whereby we finally learnt the association between this condition and acute rheumatism. In 1870, and again in 1884, he described fatal cases of chorea in which severe cardiac lesions were discovered after death. This brings us to another and the most important manifestation of acute rheumatism, that is an acute inflammation of the heart or carditis. This is much more serious than any other feature of the disease. The arthritis and St. Vitus's Dance both clear up completely and, while unpleasant in the acute phase, leave behind no permanent sequelæ. It is far otherwise with the carditis. Although recovery takes place, permanent scars are left in the heart which, sooner or later, lead to cardiac failure and finally the death of the patient.

Acute rheumatism is essentially a disease of childhood, and the vast majority of cases develop first during the years of school life from five to fifteen. Once a child has had an attack of acute rheumatism, instead of being immune to further attacks, as after an attack of diphtheria, he or she is very likely to develop a fresh attack within two or three years. It is these repeated attacks which leave the child at the age of sixteen or seventeen with a severely damaged heart. Not all cases of acute rheumatism show clinical evidence of involvement of the heart. However, there is reason to believe that the heart is affected in many cases where no abnormality is detected by ordinary examination. Some of you will remember that when Dr. Carey Coombs gave this lecture in 1925, he drew your attention to the main causes of heart disease and showed you the important part played by acute rheumatism. As a result of Dr. Carey Coombs's investigation in Bristol we were enabled by the Harmsworth Trustees to make a similar study in a number of large teaching hospitals throughout Great Britain. The figures collected then show that 38.4 per cent. of all cases of heart disease admitted to these hospitals in 1932 were due to acute rheumatism (Perry, 1934). The condition is, however, in many ways rather worse than this since the other main types of heart disease develop relatively late in life, whereas rheumatic heart disease incapacitates and kills at the prime. A study of the Registrar General's returns show that the vast majority of cases of death from heart disease under forty are due to acute rheumatism.

It has long been realized that there are striking differences in the incidence of acute rheumatism amongst different sections of the population. It became increasingly clear that the better-off members of the community were much less liable to this unhappy disease than the poor.

Sir Frederick Still, in 1927, found that of 1,000 consecutive out-patients seen at King's College Hospital Out-Patient Department 13.1 per cent. of those aged 6 to 10 showed evidence of rheumatic infection, whilst among 700 consecutive patients of the same age seen in private consulting practice only 5 or 0.7 per cent. showed signs of the disease. In 1930 Dr. Alison Glover (1930) stated that "no disease has a clearer cut social incidence than acute rheumatism, which falls perhaps thirty times as frequently upon the poorer children of the industrial town as upon the children of the well-to-do." This striking social incidence holds good all over the world, and in a study made in New South Wales in 1937 by Maddox (1937) it was found that in Sydney by far the majority of the patients came from the poorer industrial quarters of the city and very few from the better class suburbs. Apart from the social incidence it appeared that urban populations are more susceptible than rural. As a result of a discussion on the incidence of acute rheumatism at the Portsmouth meeting of the British Medical Association in 1923, a sub-committee was appointed to investigate the problem further. This sub-committee finally advised that an enquiry into the environment under which rheumatic heart disease arose in childhood should be conducted in an area defined as that included within the boundaries of the three counties of Gloucestershire, Somersetshire and Wiltshire. This enquiry was made during the three years from October, 1927, to September, 1930, and was aided by a grant from the Medical Research Council. It revealed a striking difference between Bristol and the surrounding counties. In Bristol there was found 7.72 cases for every 1,000 school children, whereas in Bath the incidence was 1.28, in Gloucestershire 1.03, in Somersetshire 2.17 and in Wiltshire 1.5 (Savage 1931). Thus we now had definite evidence that there was something in the social conditions prevailing in Bristol which was conducive to rheumatic heart disease. Since Bristol is a fairly large city and there are, within the city itself, very varying environmental conditions it appeared desirable to analyse the incidence in Bristol in more detail. This analysis was made on the basis of the City wards, since this was the only small unit for which information as to population was available (Perry and Roberts, 1937). It revealed the striking fact that in Redcliffe 3.87 cases occurred during the three-year period of the survey for every 1,000 persons and that in the same period the incidence in Redland was 0.15 cases per 1,000. Thus there was a larger difference between different areas of the city than between Bristol and the surrounding counties. We tried to find some other factor about which information was available in the different wards of the city which might show a similar relationship and we soon found that the degree of overcrowding expressed as persons per room showed a close correlation. In fact, Dr. Fraser Roberts who studied the

figures stated that on the average the incidence of rheumatic heart disease per ward rises steadily in a linear manner as the density of persons per room increases.

This clear-cut relationship to overcrowding does not necessarily mean that the overcrowding in itself is the cause of the increased incidence of the disease. Over-crowding is merely one manifestation of poverty and the larger the family income the more rooms they are likely to inhabit.

Studies made before the Bristol investigation and published by the Medical Research Council (1927), while agreeing that there are marked social differences in the incidence of acute rheumatism, suggested that it is not the poorest members of the community who suffer most severely from the disease, but those slightly better off. It was said that the family in receipt of poor-law relief was less susceptible than the family just managing to make both ends meet. However, all these studies were open to serious criticism as to the suitability of the controls used. In most cases these were hospital out-patients not suffering from acute rheumatism, but it is clear that these patients were derived from much the same economic level. It therefore appeared desirable to check these findings and to obtain further and more accurate information. In 1937 the University of Bristol with the help of the Colston Research Society embarked on a social survey of the city. This provided a magnificent opportunity to investigate fully the social incidence of acute rheumatism. The social survey would provide us with the perfect control since we should know exactly the social status of a complete cross-section of the population of Bristol. Further, owing to the organization of the school medical department and the consultative rheumatic clinic at the General Hospital we had accurate information about nearly every rheumatic child in the city. The Medical Research Council came to our help and met the cost of extending the social survey to include all the rheumatic families. In order to avoid errors of diagnosis rheumatic heart disease, which can be fairly easily and definitely diagnosed, was chosen as the criterion of rheumatic infection. The survey included all families containing one or more children between the ages of 5 and 14, who had shown evidence of active rheumatic heart disease in the preceding eighteen months. You will remember that the general social survey only concerned itself with the families of manual workers and black coated workers with incomes not exceeding £5 per week (Tout, 1938). After the rheumatic families had been surveyed Mr. Tout rang me up and complained that I had removed from the list of cases which I had provided nearly all those above this income limit. Actually I had exercised no selection, but had included all cases as already defined. Three or four families only proved, when visited, to have incomes in excess of the limit. One or two families had left Bristol in the

interval between the illness and the survey, but in all information was obtained from 341. From the sample of the total working-class population, families containing one or more children of school age were abstracted to serve as controls for the rheumatic families. The total number of such families was 1,424.

The final analysis of the information obtained in this way has been published by Dr. Daniel in the Journal of the Royal Statistical Society (1943). Dr. Daniel was able to investigate the relationship between the incidence of rheumatic heart disease and the net income of the family. By the net income is meant the money available for expenditure on food, clothes and fuel after that spent on fixed items, such as rents, rates, travelling expenses, insurance, trade union subscriptions and other regular payments has been subtracted. It is clearly not the total family income which is likely to affect susceptibility to disease as much as the income of the family relative to its needs. Thus the total income must be adjusted according to the size of the family and the age and sex of its members. In the social survey the minimum needs of each family was calculated, with slight modifications, according to the standards laid down by George. Dr. Daniel also studied the relationship with overcrowding and also the use of basement rooms, receipt of meals or milk at school and the membership of a doctor's club.

Taking the net income first. The families were divided into eight groups according to the net income expressed as a percentage of the minimum needs. There is a marked relationship between net income and incidence of the disease, those families with an income below the calculated minimum need showing 40 per cent. more rheumatic heart disease than the average working-class families and approximately twice as many as those in the highest income group. It may be urged that the numbers studied were so small that this might be a chance distribution. In order to eliminate as far as possible this risk the figures were studied statistically by subjecting them to the standard X2 test. This shows that the probability of this distribution being due to chance is less than one in a hundred.

Turning now to the question of overcrowding, the new survey showed that families with less than 0.6 rooms per person had about four times as many cases of rheumatic heart disease as those with 1.8 rooms or more. There is thus a clear inverse relationship between the incidence of the disease and rooms per person.

In the analysis of the figures for basement rooms, receipt of milk or meals at school, and the membership of a doctor's club the figures were so small that it was not possible to make any very definite comparisons. However, they suggest that membership of a doctors' club was associated with a low incidence, but

receipt or non-receipt of meals or milk at school appeared to be associated with little difference in incidence ; while families using basement rooms had a slightly higher incidence, but one which is not statistically signficant. Dr. Daniel concluded that in Bristol in 1937 if the standards of the 30 per cent. of the working-class population with the most inadequate incomes and housing accommodation were raised to the average level of the rest of the working-class population, a decrease of 21 per cent. in the number of cases of rheumatic heart disease could be expected. And if standards of all were raised to the level of the highest 10 per cent. of all working-class families, the incidence of the disease would be roughly halved. One of the few good things which has emerged as a result of the present war is that the standards of living of the less well off has been raised and coincidentally with this there has been a marked reduction in the incidence of the disease. This wartime decline in acute rheumatism has recently been studied by Dr. Alison Glover (1943), who draws attention to the fact that there has been a steady decline since 1934, and that this decline has been accelerated during the war years. Thus in 1934 there were nearly 550 deaths from rheumatic fever, whereas in 1941 this figure had fallen to less than 200. These figures are derived from the Registrar General's returns for the whole country. A similar trend has been seen in Bristol where the incidence amongst school children was 3.9 per 1,000 in the two years 1938–39, and only 1.4 per 1,000 in 1941–42.

While the close association between the incidence of acute rheumatism and the standard of living of the community is clear the actual factor responsible for this association is unknown. In these days of the realization of the important part played in the maintenance of health by an adequate diet with a proper complement of vitamins and other essential food factors it is tempting to blame some dietetic deficiency. However, no definite evidence of this has been found despite several dietary surveys. There are some who believe that the overcrowding itself is at fault by facilitating frequent upper respiratory infection.

There is no doubt that infection plays a large part in the causation of acute rheumatism and I should be wrong if I gave you the impression that social conditions are the only important factor. While no one has succeeded in demonstrating any causal organism, as in the case of typhoid fever, we have learnt that in certain patients an upper respiratory infection, a simple sore throat or tonsillitis, due to a certain organism, the hæmolytic streptococcus, is often followed, after ten to thirty days interval of apparent good health, by an attack of acute rheumatism. The infection appears to pull the trigger when the gun has been suitably loaded.

Another factor of importance is heredity. Some families have

a definite predisposition to the disease; a very good example of this is the pedigree recently published by Dr. Pickles. Nevertheless it is interesting to note that when children from the social class in which acute rheumatism reaches its highest incidence are removed from their home environment the incidence is considerably reduced. Thus the Medical Research Council report showed that children living in certain poor-law residential schools were relatively free from rheumatic infection compared with children of their own class who were living at home. Newman found that amongst the mentally deficient children at Fountain Hospital, Tooting, the incidence of acute rheumatism was 0.4 per cent. whereas Glover estimated that amongst the elementary school children from which the inmates of Fountain Hospital were drawn it was at least 2 per cent. Professor Nixon drew attention in 1934 to the very low incidence of the disease at Stoke Park Colony where there are some 1,500 inmates. This apparent immunity to the disease of the children at Stoke Park has persisted and Professor Nixon tells me that he has never seen a case of a first attack of acute rheumatism in the Colony and that Dr. Bates, the Medical Superintendent, has no records of any such case. Such observations as these suggest that however large a part heredity may play in the production of the disease the environment of the child is far more important.

Of the various factors known to play a part in the causation of this serious disease the social environment is the only one capable of control. At the moment we have no means of preventing streptococcal infection in the general population, although there is some hope that we shall in the near future be able to control this infection in small groups. Heredity is clearly beyond any hope of control in the present state of our knowledge but standards of living can be improved.

Apart from the important rôle of environmental conditions in the causation of acute rheumatism social conditions create further difficulties for the patient. When children with rheumatic heart disease leave school many of them have great difficulty in obtaining suitable employment. Some of them are backward as a result of lost schooling through illness, but the more fortunate will have escaped this drawback if they have been treated at a properly equipped hospital school like Winford. There are, however, at the moment only a few such institutions. The majority of these children have hearts which, although damaged, are quite adequate for their immediate needs. They have no symptoms and are able to lead fairly normal active lives. It is clearly undesirable for them to enter laborious occupations, but they are well able to do ordinary factory and clerical work. However, there are two difficulties in their way under ordinary peacetime conditions. All grades of the civil service and many similar types of employment

are closed to them by reason of the superannuation schemes. They fail to pass the ordinary medical examination and are rejected. Even where no such scheme exists the larger and better factories insist on a medical examination on entry, partly as a safeguard against the risks of employers' liability. Again these children are rejected although perfectly capable of doing good and useful work. As a result they drift into unsuitable occupations, the boys often becoming errand boys where they are exposed to all winds and weathers and have no future prospect to look forward to. Under wartime conditions these difficulties have largely disappeared since nearly anyone is able to obtain employment. But even now this is not always suitable. It should be realized that nearly everyone, however crippled, is capable of doing some work of value to the community. Under the necessity of compensating for wartime shortage of man power, the United States Civil Service Commission, the central recruiting agency for the Federal Government, has shown that thousands of jobs in industrial establishments of the government, such as arsenals, can be filled by judicious placing of physically handicapped persons. (Harvey & Luongo, 1943). An attempt has been made to work out a system of grading according to the disability suffered, including different types of heart disease. This, of course, necessitates an accurate medical assessment as a preliminary. It is to be hoped that that part of the Beveridge Report which recommends vocational training and subsequent employment for the physically handicapped will considerably lighten the lot of the unfortunate child suffering from rheumatic heart disease.

I must apologize if, in this short survey, I have paid undue attention to studies made in Bristol, but I felt that a Bristol audience would be interested to hear of this work. I have attempted to show you how social conditions help to cause an important disease and afterwards may make the life of a sufferer from that disease unnecessarily difficult. In this way I hope that I have carried out the exhortation of Dr. Long Fox when, in the address to which I have already referred, he told us that as medical men we should "concern ourselves with the well-being of the masses of mankind, the possibilities of the advancement of the race, the annihilation of all things that militate against the progress of the nation."

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"LOOK AND SEE,"

Foreign Bodies in Air and Food Passages,

BY

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When a patient complains of "something stuck in the throat," there is only one sound rule: examination *by endoscopy* as soon as arrangements can be made. We may make an exception when the object in question is known to be metallic, for even a small fragment of metal shows readily in a radiographic film. But it is extremely difficult to detect small portions of bone within the thorax, amid the crossing shadows of ribs and vertebral processes, while cartilage, glass, "composition" buttons, and so forth, may be completely transradiant.

It is not always easy to keep this rule. One may examine five or six patients in succession with negative results; yet the seventh may be in actual danger from such an intruder, though presenting exactly similar symptoms. Insane persons, convicts and those awaiting trial not uncommonly swallow pins, nails, etc., to earn removal to hospital for investigation. Fortunately such persons generally choose metallic bodies. Sometimes also one encounters a patient who repeatedly claims to have something stuck in the throat. Quite recently I saw a young woman who made this claim three times in eight months, without any foundation, but appearing genuinely distressed each time. The only apparent motive was to get her husband home on compassionate leave!

The case may present as one of disease of these parts with no history pointing to the presence of a foreign body. The patient may be actually ignorant of any accident, too young or too frightened to tell about it—or even disbelieved when giving a clear and definite history.

Finally, the fact that a foreign body has been coughed up or has passed *per vias naturales* is not conclusive: there may be more than one.

Endoscopy is a simple and safe procedure. The worst treatment

possible is blind poking about with a probang or coin-catcher—ingenious devices of the last century whose only place is now in the Museum.

Case 1. Anita O., aged 7, was admitted in 1931, with severe respiratory obstruction—so severe that all the accessory muscles were called into action and there was very pronounced "sucking-in" not only of ribs and lung apices, but also at the sides of the trachea: this suggesting that the obstruction was above the sternum. The history was given that the condition had come on during six weeks, since the child had choked over an orange pip. The voice was weak, but clear: coughing very feeble, no expectoration: slight evening pyrexia.

Under local ("Tutocaine") anæsthesia I carried out direct laryngoscopy. No foreign body seen, glottis normal: the lumen of the trachea appeared to be completely obstructed by granulations. A soft rubber tube was passed through this mass, giving immediate relief; and a general anæsthetic administered. Tracheotomy was then performed, dividing the second, third and fourth rings of the trachea. No foreign body was found, so the "granulations" were removed as thoroughly as possible and the tracheotomy tube left in situ. The material removed was reported "round-celled sarcoma." I inserted radium 25 milligrammes, filter 0.5 mm. platinum and 0.5 mm. gold, total dose 3 gramme-hours: respiration was carried on through a *lower* tracheotomy.

In removing the radium, after the anchoring stitches had been removed, the safety silk broke, and the container fell down the trachea blocking it completely. The child was seized by the pelvis, head-down: a good shake shot the container into sight, and it was removed. As I mopped my forehead she whispered, "I didn't cry, did I, Sister?"

The child made a complete recovery, although the tracheal cartilages perished after the irradiation and the tube had to be retained. She became head of her school, was captain of tennis, gymnastics and hockey (and felt sure she could have been captain of swimming, had it not been for the tracheotomy!) and won a county scholarship. I have heard recently that she is married and has a child, born in 1943. It is curious that her father died of cancer of the bronchus in 1937.

Case 2. Nine years ago a large, robust butcher, aged 48, came to me complaining of gradually increasing difficulty in swallowing during six months. No solids could pass, and even fluids were sometimes returned: it felt as if the obstruction was behind the lower end of the sternum. There was occasional dull, aching pain in the back behind that point. He had lost a stone in weight, but was certainly not thin. X-rays showed a stricture of the œsophagus 2 inches above the diaphragm, with moderate dilatation above. Diagnosis: cancer of œsophagus.

I passed an œsophagoscope, and 34 cm. from the incisor teeth. I found a green foreign body, rather firmly held by spasm of the œsophageal walls, which were ulcerated. On removal it proved to be a flake of bone, roughly circular and 8 mm. in diameter. He had no recollection of swallowing it; but had been in the habit of

FIG. 1.
Hair-pins in œsophageal entrance.

FIG. 2.
The hair-pins after removal: scale of centimetres.

FIG. 3.
Right Bronchiectasis: Note that right side of chest appears on right.

FIG. 4.
Lateral view of bronchiectasis.

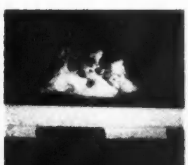

FIG. 5.
Bone from right bronchus
scale of centimetres.

eating scraps of raw fat while at work and thought it might have been swallowed accidentally in this way. It is unusual for a foreign body to become arrested so far down in the œsophagus. Recovery was rapid and complete.

Case 3. Miss E., 49, was sent to me in 1942, complaining of slight discomfort in the region of the right tonsil, and inability to swallow hard solids for some years. She had had this difficulty with hard solids all her life. Four years previously she was depressed, and it was necessary to certify her. On arrival at the mental home she realized what was happening, and when alone for a moment rolled up two hair-pins into a ball and swallowed them. At once she became inarticulate, but pointed to her throat and made it clear that she thought there was something stuck there; but this symptom had been present for some time, and was not specially regarded. She soon regained her power of speech, but could—or as it was considered, would—take nothing but slops. She complained several times of attacks of severe pain high up in the throat, or at the back of the mouth; and told her attendants that she had swallowed hair-pins. But she was assured that these had passed per vias naturales, and urged not to let herself dwell on the delusion, which was the only remaining unfavourable mental symptom.

As her general mental condition had improved she was discharged to the care of relatives; and although she continued to complain of the hair-pins in the throat, her friends and doctor urged her to forget it (in fact, it seems that she was told if she continued to complain she would have to return to the Mental Hospital).

In July, 1942, she consulted another doctor, who felt that "to satisfy her" an X-ray examination should be made; upon which a tangled mass of wire was shown in the region of the epiglottis (Figures 1, 2). When she came to me it was easy to see loops of metal behind the base of the tongue, but the mass was so firmly embedded that to remove it a general anæsthetic and wire cutters were found necessary.

Case 4. Mr. L., 50, was sent to me recently with the diagnosis of cancer of the bronchus. In October, 1943, he began to be troubled with shortness of breath, wheeziness and expectoration—the latter rapidly became profuse and offensive. Three weeks before this he had choked over a bone, he said, while eating mutton. But there was no difficulty in swallowing, and as his own doctor was ill he thought little of it; though he mentioned the incident when he saw the doctor for the "bronchitis." He was sent to the local hospital and his name was put down for admission, but after five months, as symptoms increased and he was not sent for, I was asked to see him.

An X-ray showed considerable opacity in the right lower lobe; and the fetid sputum was obviously coming from a bronchiectasis or similar lesion. None of the X-rays showed any foreign body (Figures 3, 4), so the history of this had been considered unimportant.

On passing a bronchoscope I found the right main bronchus full of foul pus, which welled up freely: so that several minutes had to be devoted to removing this by suction before proceeding further. The walls of the bronchus were sodden and inflamed and at the junction

of the eparterial bronchus I found a white irregular bone embedded in granulations. It was so large (Figure 5) that it would not pass through a 10 mm. bronchoscope and therefore had to be withdrawn in the forceps protruding from the end of the instrument. Unfortunately severe damage has been done to the lung by this protracted stay and the ultimate prognosis is not good.

Case 5. A mongol idiot, aged 3, was admitted to a local hospital with acute intestinal obstruction. The condition resolved when an enema brought away a large "composition" coat-button. But ten days later the child was refusing all food, though it would drink. The mother was sure there must be another button stuck in the throat. X-rays showed no foreign body; though when barium was given there was some delay in passing this from the level of the upper edge of the sternum.

Under ethyl chloride anæsthesia I passed a laryngoscope and found a button of 28 mm. diameter (a little larger than a half-penny), rather firmly gripped in the œsophagus, the upper edge 1.5 cm. below the cricoid; the lateral walls of the œsophagus were ulcerated and bleeding. I was able to break the button up into five pieces and thus to remove it—making sure, of course, that the pieces fitted together to make the complete button.

These five cases illustrate the great importance of an early and thorough examination *by endoscopy* in all cases of disease of the œsophagus or the main bronchial passages, and particularly if there is even a possibility of a foreign body having lodged there. While it is rare for life to be immediately threatened, unless larynx or trachea is involved, there should be no delay in getting expert help; the complications that may follow retention of a foreign body in these parts are often crippling and sometimes fatal.

SUMMARY.

The five cases cited may be summarized thus:—

1. Suspected foreign body in trachea found to be sarcoma.
2. Supposed cancer of œsophagus found to be unsuspected foreign body.
3. Foreign body in hypo-pharynx, for years dismissed as delusion.
4. Supposed cancer of bronchus found to be foreign body; severe bronchiectasis owing to delay in examination.
5. Second foreign body in œsophagus of idiot, first having passed per vias naturales.

EDWARD TYSON, M.D., F.R.S., 1650–1708

Anatomist and Anthropologist.

PROFESSOR ASHLEY MONTAGU, Associate Professor of Anatomy in Hahnemann Medical College and Hospital, has recently published a full study of Dr. Edward Tyson's life and work, in which he has made this great anatomist and anthropologist the central figure in a full and well informed account of the rise of human and comparative anatomy in England.

"Here," says Ashley Montagu, "was a very great man indeed, one whose contribution to human thought and welfare, to science, and to medicine, alone entitled him to rank among the greatest figures of his own or any other day."

Edward Tyson was born in the parish of St. Nicholas, Bristol, on the 20th of January, 1650. His father (also Edward) was a citizen of standing who at various times held the offices of Sheriff, Alderman and Mayor of Bristol; his grandfather (another Edward Tyson) who lived in Bristol and afterwards at Clevedon, was a man of considerable wealth who came of an old Cumberland family. Dr. Edward Tyson was educated in private schools in Somerset, then proceeded to Magdalen Hall, Oxford, where he took the Degrees of B.A., M.A., and Bachelor of Medicine.

The remainder of his life was spent in London, but he did not forget his native city, for he gave £100 to St. Peter's Hospital when it was opened in 1696 by the Corporation of the Poor of Bristol, and he made a gift to St. Stephen's Church, known as "Dr. Tyson's Sermon Gift," settling a sum of money to perpetuate the annual sermon founded "by his grandfather Mr. Tyson of this parish." Later he gave further donations to St. Peter's Hospital.

Edward Tyson was one of the original members of the Royal Society and made many scientific contributions to its meetings, mainly of an anatomical nature. Ashley Montagu holds him high, as one of the first to insist on the gradational conception of the relations of living things. As a dissector and anatomical observer Tyson was unsurpassed, but Ashley Montagu gives him credit for having founded the study of comparative anatomy and the methodical investigation of the natural history of animals. The work which in his own day brought him the widest reputation was the book entitled "Orang-Outang, sive Homo Sylvestris, or the Anatomy of a Pygmie, compared with that of a monkey, an Ape and a Man," published in 1699.

Huxley described this as "the first account of a man-like ape which has any pretensions to scientific accuracy and completeness."

It was based on a dissection of a young Chimpanzee which had been landed in Bristol in a dying state.

But Tyson did not stop at Natural History or comparative anatomy. Before his time purposeful autopsies were unknown. He showed what could be achieved in this way by carefully observing and describing the course and the symptoms of disease and comparing these with the findings upon the autopsied body of one who had succumbed to the disease.

He described anatomical anomalies such as horseshoe kidney and double ureters; he gave in 1683 the first clear picture of the character of the tapeworm and the round worm. He discovered the true nature of hydatids and cysticerci. Curiously enough, the mucilaginous glands of the penis, which he discovered and to which his name is attached, were not the subject of any communication or publication of his own. William Cowper his collaborator in anatomical studies mentioned in passing that Tyson had discovered these glands.

Then, to Ashley Montagu's regret, Tyson became overwhelmed with the claims of a busy London practice and appointment as physician to Bethlehem Hospital. At this Royal Hospital he was one of the greatest reformers and a great benefactor.

The sympathetic treatment of the patients which he introduced is now one of the traditions of the place. Moreover he organized after-care and follow up of discharged cases in order to prevent relapse. In this province of medicine he left an example, but no published writings.

Tyson never married; he was a man of notable taciturnity, "a most understanding anatomist, and a good physician, yet" an Irish acquaintance, Thomas Molyneux, relates "in strange company modest even to an imperfection." But Molyneux found he had some humanity about him, "his studies were his chief delight, only he took now and then a touch at fishing."

As Professor George Sarton of Harvard says in his foreword, "Ashley Montagu has given us in a generous way a full-length portrait of Edward Tyson for which we are grateful."

The enthusiasm and meticulous care with which he has studied every piece of Tyson's work and every contemporary mention of him are indeed admirable.

We are grateful indeed to be reminded of this illustrious son of Bristol.

REFERENCES.

Edward Tyson, M.D., F.R.S., 1650–1708, *and the rise of human and comparative anatomy in England; A Study in the History of Science*, by M. F. Ashley Montagu, Assocate Professor of Anatomy, Hahnemann Medical College and Hospital, Philadelphia. *American Philosophical Society Memoirs*, Vol. XX. Price $5.00.

THE GOODENOUGH REPORT ON MEDICAL EDUCATION

A Summary

THIS Report of the Inter-Departmental Committee on Medical Schools is both interesting and important. Some readers will receive it with surprise at the innovations it suggests, others will think it is not progressive enough. But no Committee can ever issue a report that is really ahead of the general views of the public whose witnesses it has examined. The members of the Committee and its Chairman, Sir William Goodenough, are well known and well trusted both by the public and the medical profession. The most interesting reading comes at the end in Appendix P, where the names of the witnesses are recorded.

Every university in the United Kingdom and all the teaching hospitals submitted evidence, as well as all the licensing Corporations and Royal Colleges, Municipal Corporations, County Councils, the G.M.C., B.M.A., the British Hospitals Association, the Medical Research Council, Medical Students Associations of England and Wales, and Scotland. The Pathological Society, British Pædiatric Association and the 1942 Club were all heard, and in addition thirty-seven independent witnesses. Many other professional organizations and hospitals sent written evidence, but were not heard orally.

From this plethora of witnesses there has emerged a Report signed unanimously by the members of the Committee, without any dissentient or unsatisfied voices. This in itself is remarkable, but it probably results from a marked degree of unanimity in the evidence heard and read. The reception of the Report has so far as can be judged from early comments in the medical and public press been enthusiastically favourable.

Some of the outstanding observations made by the Committee are worthy of record without comment. Readers may individually agree or disagree with the Committee's conclusions, but they should remember that the Committee heard the evidence, weighed it in an impartial balance and gives its judgment with impartiality, without fear or favour, and most important of all without one "dissenting judgment." Not every Court of Law achieves the same unity of judicial opinion. In brief, here are the conclusions :—

A successful National Health Service depends on Medical Education. Many of the necessary reforms in Medical Education depend upon a change of outlook on the part of teachers and examiners and upon the development of new teaching methods.

Immediate action is needed on three matters :—

1. Building up an adequate supply of teachers.

2. Financial and other assistance to medical schools for provision of staff, accommodation and equipment that will be needed.

3. Provision of suitable post-graduate courses for existing practitioners.

Other recommendations are :—

That every Medical School should be an integral part of a University. This involves radical changes in the relations between the University of London and the London Teaching Hospitals. It also carries with it the cessation of training medical students by the extra-mural schools in Scotland.

In order to remedy defects in the staffing of Clinical Departments it will be necessary

(*a*) To create more whole-time appointments in all grades, senior, intermediate and junior.

(*b*) To adopt new machinery for selecting clinical teachers and members of staffs of teaching hospitals and for diminishing "in-breeding."

(*c*) To pay salaries to clinical teachers for defined duties.

(*d*) To re-organize the educational work of clinical departments so that each such department may have an academic head responsible for the general organization and direction of teaching and research.

As regards whole-time appointments, the general body of evidence is in favour of more whole-time teaching appointments in clinical subjects. It is therefore recommended that every Medical School should have whole-time professors in the departments of general medicine, general surgery and obstetrics and gynæcology. But it is not proposed that clinical teaching should be solely in hands of professors and whole-time teachers. Specialists who are part-time teachers have essential contributions to bring to the training of medical students.

The Report considers that training has, in some instances, suffered because too many students have been attached to an individual teacher for bedside teaching. The number should be limited to six or eight. In every medical teaching centre an adequate staff of non-medical technical assistants is essential. Universities should be responsible for recruiting, training and providing reasonable amenities for them.

The appointment of Regius Professors by the Crown should cease and be transferred to the authorities of the Universities concerned.

Students.—Co-education of men and women should be the rule, and unsuitability for a medical career should be the sole barrier to admission to a Medical School.

Financial grants to medical students should be adequate in amount, should cover the whole period of training, and should include cost of maintenance throughout.

The selection of students should not be based on examination results alone. Selection should be based on the candidate having received a good general education, on confidential reports on his previous career and on the impressions gained at an interview.

Moreover, selection machinery must extend to the early weeding-out of students who prove unsuitable.

There are many observations on the number of students at various centres, the upshot of which is the desirability of reducing the number of students admitted to Aberdeen, Edinburgh and Glasgow, and the geographical re-distribution of medical schools in London.

The University of Oxford is advised to develop a small clinical school aiming at producing "teachers, investigators and consultants, rather than general practitioners."

The University of Cambridge is advised that the building up of active post-graduate clinical departments should precede the establishment of an undergraduate clinical school.

Pre-Clinical Studies.—It is held that training in physical and biological sciences is best begun at school, but this will involve changes in the school curriculum and examinations, as well as increased and better teaching in these sciences at school. Training in the physical and biological sciences should be continued at the Medical School in close association with the training in anatomy and physiology.

There is urgent need for a new view-point of the part of teachers of pre-clinical subjects and for the drastic elimination from their teaching and the examinations of a mass of detailed information.

Clinical Studies.—Since the majority of students become general practitioners, clinical teaching must be largely directed to the problems that most frequently face them in general practice.

General medicine, minor ailments, common diseases, early stages of disease, chronic diseases, infectious diseases and rehabilitation must receive more attention.

The surgical part of the undergraduate course should be closely correlated with other undergraduate work.

The technical details of operative measures are matters for post-graduate study. Undergraduate training should be directed to the recognition, early treatment, personal, social and economic effects of those surgical conditions commonly encountered in general

practice (acute injuries, acute infections, abdominal emergencies and malignant disease).

Social and preventive medicine, child health and disease, psychological medicine and maternity work must receive more attention.

After passing the Final Qualifying examination every student should be required to serve as a junior house officer for a period of twelve months in one or more approved hospitals before admission to the Medical Register and being permitted to enter independent medical practice.

Final Examinations.—In order that the burden of final examinations may be relieved and students encouraged to pay proper attention to all parts of the training "internal" departmental examinations in suitable subjects should be instituted as a complement to the final examination.

One effect of the recommendations, if adopted, will be the abolition of the qualifying examination as at present conducted by Licensing Corporations which have no responsibility for teaching.

This review does not deal with Part II of the Report "Postgraduate Medical Education and Research."

Reviews of Books

The Medical Annual, 1944. Edited by Sir Henry Tidy, K.B.E., and A. Rendle Short, M.D., F.R.C.S. Pp. xxvi., 404 (71). With 40 plates. Bristol: John Wright & Sons Ltd. Price 25s. net.—Readers will be glad to know that a slightly larger number of copies of the edition of 1944 has been printed owing to some concession by the Ministry of Supply. Hitherto the war editions have been far smaller than the number of would-be-purchasers. Wright's *Medical Annual* remains the favourite Compendium of the English speaking medical world. The 1944 edition is full of up-to-date and important items. Among these should be mentioned infective hepatitis or catarrhal jaundice, which is now at last adequately explained. In the article on radiology, mass radiography of the chest is critically and cautiously appraised. There is some hint that it may take its place among other Government schemes for making "worlds fit for heroes." Radiotherapy is admirably reviewed. The importance of malaria at every stage of the world war cannot be exaggerated, and there are two excellent articles—one by Manson-Bahr on the general problems of malaria, and another by Heathcote on quinine and its substitutes in the treatment of malaria. The directions for treating cases of relapse in Great Britain are inadequate, not from any fault of the reviewers but because the subject has not met with sufficient attention since the late Professor Warrington Yorke's masterly article in the *B.M.J.* of July 18, 1942. The various articles on war wounds, war surgery and burns will repay careful reading; so too will Aubrey Lewis's summary on war psychiatry. But every reader will pick his own subjects, and none is likely to be disappointed. Wright's *Medical Annual* is as good as usual.

The History of Cæsarean Section. By J. H. Young, M.B., Ch.B. Pp. viii., 253. London: H. K. Lewis & Co. Ltd. 1944. Price 16s. net.—This book is remarkable in that so much of interest and instruction has been packed into such a small compass: for probably every student and obstetrician, or would-be obstetrician, will find here matter of help to him in his practice. The book and its bibliography will also give great satisfaction to the historian, as he reads of the early efforts to win success in this operation, efforts which seemed to have failed until the opening of the present century. Then the latest methods of performing the operation having been proved safe, it became for a time almost fashionable and the cure-all for many obstetric difficulties. One cannot help being impressed with the many conditions which have been treated by this operation for a time, only to give place later to other more conservative treatments. As with the indication so with the methods. We are shown the mistakes in methods of doing the operation from the days when the uterus was not sutured until the

present day. Similarly at various times many and varied incisions have been used in all parts of the uterus: fundus, back, cervix, lower segment, etc., and in all directions, diagonal, vertical and transverse. In fact, if anyone contemplated doing a "new" method either of incision or suturing, it would be very difficult to find one which is not described in the book as having already been "tried" and—in many instances—"found wanting."

Synopsis of Surgical Anatomy. Fifth Edition. A. LEE MACGREGOR, M.Ch., F.R.C.S. Bristol: John Wright & Sons Ltd. 1943. Price 25s. net.—The fact that two reprints of this book, followed by the present Fifth Edition, have been required since the outbreak of the war are a sure indication that it meets the requirements of those for whom it has been produced. The present edition shows evidence of thorough revision, and a good deal of new matter has been added, particularly in the section devoted to the autonomic nervous system. This revision has been most thoroughly done, and an enormous amount of information is contained in the pages devoted to it. The whole work is packed with anatomical detail arranged in a convenient way for ready reference. Here and there, perhaps, can be found instances where a little more detail would not be out of place, witness the rather casual reference to Meckel's diverticulum. On the whole the book is complete and accurate, and likely to be of the greatest use to those for whom it has been written. It is, perhaps, rather strong meat to be used as a systematic text-book for the student, to be read from cover to cover. As a book of reference, however, and to those reading for higher qualifications, it should meet a real want. The illustrations are numerous and helpful, and the index is adequate. A final word of congratulation should be awarded to the publishers for the way they have overcome the difficulties of book-production under present circumstances.

Symptoms and Signs in Clinical Medicine. Third Edition. By E. NOBLE CHAMBERLAIN, M.D., M.Sc., F.R.C.P. Pp. viii., 456; 346 illustrations. Bristol: John Wright & Sons Ltd. 1943. Price 30s.—There is really little to add to the whole-hearted commendation expressed when this excellent work first appeared. The book is sumptuously produced and beautifully printed. How the publishers have been able to do such work in view of their difficult experiences is in itself a problem. The book itself is somewhat expanded: a chapter on Radiology is added. We note with interest (and perhaps a little relief) that the author still believes in mitral regurgitation. It is difficult to think of a better guide for the student in his approach to clinical medicine: accurate, interesting and concise. Modern students are indeed fortunate to be provided with such an aid to intelligent examination and diagnosis.

Electrocardiograms. Second Edition. By H. WALLACE JONES, M.D., M.Sc., F.R.C.P., and E. NOBLE CHAMBERLAIN, M.D., M.Sc., F.R.C.P. Pp. 56. Illustrated. Bristol: John Wright & Sons Ltd. 1943. Price 5s. net.—The appearance of a second edition of this atlas in four years is sufficient proof that it has proved of value to students

and practitioners. This is hardly surprising. The book is well produced with excellent illustrations. The text is clear and simple. This atlas thus provides a very good introduction to electrocardiography without going deeply into theoretical considerations which are of no practical importance to the ordinary student. Apart from illustrating the main features of the electrocardiogram it indicates the type of case in which this method of investigation is likely to be of value to practitioners. (The only error noted is that Fig. 49 has been printed upside down.) It can be thoroughly recommended.

First Aid Treatment of Home Guard Casualties. By THOMAS HENRY MEEK, M.D. Pp. vii., 55. London: H. K. Lewis & Co. Ltd. 1943. Price 4s. net.—This booklet attempts to explain to the Home Guard the essentials of first-aid treatment in the field. The material, presented concisely in non-technical language, is sound as far as it goes, but there are serious omissions: no mention of the order in which casualties should be evacuated; no suggestions of priority for abdominal wounds; no stress on the importance of avoiding exposure while applying dressings—the illustrations suggest the casualty should first be stripped naked; no mention of the simple expedient of up-ending the stretcher to clear the bronchi of blood or other fluid, or of the danger of forceful artificial respiration in chest injuries; no suggestion that all gassed cases should be transported lying flat. The best section describes the order for dealing with casualties. The appeal of this book would be wider were it produced as a "Penguin" for ninepence, than for four shillings in its present form.

Common Skin Diseases. Seventh Edition. By A. C. ROXBURGH, M.D., F.R.C.P. Pp. xxxii., 454. Illustrated. London: H. K. Lewis & Co. Ltd. 1944. Price 18s. net.—The latest edition of this well-known text-book on dermatology has been considerably expanded and brought up to date, without any appreciable increase in bulk, so that the volume remains of convenient size. The paper and print are good, and the many illustrations, which include eight coloured plates, are excellent. The chapter dealing with scabies describes fully the latest methods of treatment of this infestation, with special reference to the findings of wartime research workers, such as Mellanby. There is valuable information on the subject of industrial dermatitis, its causation and prophylaxis. A whole chapter is devoted to a summary of the recent work on avitaminosis, and the skin lesions associated with vitamin deficiencies are described in detail. A final section deals with the condition known as immersion foot, and its treatment; also Dr. Roxburgh's own experiences in the treatment of such chronic infections as blepharitis and sycosis barbae with penicillin ointment. Several of the rarer dermatoses are mentioned, which renders the book of value to senior practitioners as well as to students and clinical assistants, for whom it was originally intended.

Massage and Remedial Exercises. Sixth Edition. By NOEL M. TIDY. Pp. viii., 480. Illustrated. Bristol: John Wright & Sons Ltd. 1944. Price 25s. net.—This encyclopædic *vade-mecum* for physiotherapists has now gone through six editions in twelve years, two of

these during the war. The indication is that there is a good demand for the book. The chapters on fractures have been enlarged and modernized (with the help of Watson-Jones's *Fractures*), otherwise there appear to be only minor changes and additions. We have little to add to our critical appreciations of the previous editions, except that this time many of the illustrations are very badly printed. However, this may be the result of bomb damage, which the publishers have suffered on at least two occasions.

Preparation and After-care of Surgical Patients. By HUGH C. ILGENFRITZ, M.D., RAWLEY M. PENICK, JUNR., Ph.B., M.D., F.A.C.S., and URBAN MAES, M.D., D.Sc., F.A.C.S. Pp. 532. Illustrated. London: Henry Kimpton. 1942. Price 25s. net.—This is a most excellent handbook, and a sound and up-to-date guide to surgeon and house-surgeon alike. Two principles are repeatedly emphasized. First, that complications are much easier to prevent than they are to treat: secondly, that post-operative care begins in the operating room. The physiological basis for each therapeutic measure advocated is discussed, and it is demonstrated that much of the future progress in surgery will develop from closer co-operation between scientific investigator and practising surgeon. There is a certain amount of repetition from one chapter to another, but the whole is clearly arranged and indexed for ready reference.

Physical Signs in Clinical Surgery. Ninth Edition. By HAMILTON BAILEY, F.R.C.S. Pp. viii., 350. Illustrated. Bristol: John Wright & Sons Ltd. 1944. Price 25s. net.—The ninth edition of this popular book is a triumph over adversity, both for the author, who lost nearly all his illustration blocks, and for the publishers, whose premises were twice destroyed by enemy air-raids. Nevertheless, it is as well turned out as ever, and as we expect in a book by Hamilton Bailey, the pictures average two on every page, and by themselves, even without the text, provide a liberal education. Methods of correct examination are shown, as well as almost every variety of surgical ailment or injury that lends itself to pictorial representation. The book is primary designed for students in the fourth to sixth year of their studies, but the doctor who glances through the pictures for a few minutes every now and then when he has a few minutes to spare will almost certainly be helped sooner or later to a correct diagnosis he might otherwise have missed. The text, if not so likely to catch the eye, is as good as the illustrations. Altogether this is a book of more than ordinary value.

Amputations and Artificial Limbs. By R. D. LANGDALE-KELHAM, M.R.C.S., L.R.C.P., and GEORGE PERKINS, M.C., F.R.C.S. Pp. 96. Illustrated. London: Oxford University Press. 1942. Price 5s.—The new Oxford War Manual on Amputations and Artificial Limbs has been written by two acknowledged experts on the subject. All useless matter has been ruthlessly cut out and only the bare essentials retained. One of the best features of the book is its description of how to pass out a limb when it has been fitted, and the points in the fitting on which to

approve or disapprove. This excellent little book should be read by all surgeons and doctors who have to deal with amputations, and also by students.

Handbook of Midwifery. By COMYNS BERKELEY, M.C., M.D., F.R.C.P., F.R.C.S., M.M.S.A., F.R.C.O.G. Eleventh Edition. Pp. x., 622. Illustrated. London: Cassell & Co. Ltd. 1941. Price 8s. 6d. —That a book should reach eleven editions is, in itself, sufficient recommendation of its excellence and many succeeding generations of Medical Students and Pupil-Midwives have found it a most useful companion. This new edition is of convenient size, well produced and illustrated, whilst the new index is an important feature. It is so arranged that the best page for a particular subject in the text can be readily found, when required. At the same time easy revision is aided. The section on diet for pregnant women also adds to the book's usefulness, and in an appendix further information on "food" is provided. Transfusion, with whole blood, plasma, serum, and saline or saline-glucose solutions is also considered in this appendix. In the past the book had a very wide appeal. In the future one may prophesy that it will prove wider still.

Scabies. By KENNETH MELLANBY, Ph.D. Pp. xi., 81. Illustrated. London: Oxford University Press. 1943. Price 5s.—Every medical man will welcome this handy pocket-sized Manual. Clear-cut, concise and excellently printed, a great deal of profit is to be gained from its 81 pages. There are some well drawn figures illustrating the life history of the acarus. The style makes for easy reading and sustained interest. After dealing with and comparing the different methods of treatment, the author comes to the conclusion, in a most convincing manner, that sulphur ointment and benzyl benzoate are the most efficient, whilst others fail in a very definite proportion of cases. Dr. Mellanby's views on the transmission of scabies are concise. He considers the disease is a domestic one, and corroborates the opinion of the Ministry of Health that disinfestation of clothes is not necessary, but considers bathing with soap, water and a flannel valuable in dirty cases. He states that the ordinary process of laundering should be sufficient to exterminate the parasite. He makes a point of the way in which the mite attacks the sexes differently, and also certain sections of the community in particular, such as soldiers. His differentiations of diagnosis are very explicit. This is a most excellent little book: the author is to be congratulated on his achievement.

Editorial Notes

New Professors. Dr. J. E. Harris, M.A., Ph.D., Cambridge, B.Sc.London, has been appointed to the Chair vacant by the appointment of Professor C. M. Yonge, to be Regius Professor of Zoology at Glasgow.

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Dr. Wilson Baker, Fellow and Tutor of Queen's College, Oxford, has been appointed to the Capper Pass Chair of Chemistry, vacant by the appointment of Professor E. L. Hirst to the Chair of Chemistry at Manchester.

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Grants for Research. For the fourth year in succession the Nuffield Provincial Hospitals Trust has made a grant of £1,000 for distribution by the Bristol and District Divisional Hospitals Council.

For the year 1944-5 the Trust has agreed that the £1,000 grant be used as follows:—

(1) £500—for the engagement of a whole-time assistant for Research into the chemoprophylaxis of acute rheumatism.

To this post Dr. D. N. Ross has been appointed. He qualified M.B., Ch.B., at the University of Glasgow, was House Physician in Kilmarnock Infirmary, and R.M.O. in Harrogate Royal Bath Hospital. He joined the R.A.M.C. in 1942, but relinquished his commission on account of ill-health.

(2) £500 to Mr. A. J. Wright for research on Mènière's Disease.

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Work only the Blind can do. From the Monthly Bulletin of the Ministry of Health and the Emergency Public Health Laboratory Service for October, 1944. We quote the following:—

Work has been found which only the blind can do—shorthand-typing in the darkness of a radiography room.

A blind typist employed at the Ministry of Health was recently transferred for duties at one of the base hospitals in the Emergency Hospital Scheme under the Department of Health for Scotland. The radiologist there—a leading consultant—found that she was able to solve one of his big problems.

Until now the radiologist has had to memorize his verdict on each

examination and make up his records at the end of a series of screenings. The room being in darkness, except for the dim glow of a red lamp at the control table, an ordinary shorthand-typist was unable to take and read notes.

Now the blind typist, with typewriter, sits at a desk in a corner of the X-ray room. When the radiologist has completed each examination, he dictates his findings, which she takes down in shorthand or immediately types out. As soon as the last patient has gone, a neat accurately typed report awaits the radiologist's inspection.

Duty in the dark room over, she assists the radiologist by taking down at his dictation his readings of X-ray films submitted to him by his radiographer. Here again, the notes are often taken down direct on the typewriter. Copies of the reports are then sent to the Medical Officers whose patients have been examined.

This blind typist has summed up her duties in these words :—" I have the unique experience of realizing that, at least in this instance, I am able to perform work which those in possession of their sight would be unable to undertake."

Obituary

WE regret to have to record the following casualties on Service :—

EDWARD MILLS GRACE, M.B., Ch.B. (Bristol), Captain R.A.M.C.

Captain Edward Mills Grace, R.A.M.C., elder son of Dr. E. M. Grace, of Thornbury, who died in March of typhoid fever in Italy. He graduated M.B. in 1939 and had held resident appointments at the B.R.I. One of his first war experiences was that of bringing back wounded from Dunkirk. Like his forbears, Grace was an outstanding cricketer and a fine all-round athlete.

LESLIE ROLAND JORDAN, M.B., Ch.B. (Bristol), F.R.C.S., Major R.A.M.C.

Major Leslie Roland Jordan, R.A.M.C., met his death whilst operating in Normandy soon after the invasion landing. He qualified M.B., Ch.B. Bristol in 1931, and obtained his F.R.C.S. England in 1934. When war broke out he was practising in Muswell Hill and was Surgeon to the Hornsey Central Hospital. Mr. Wilfred Adams writes of him :—

Leslie R. Jordan was a born devotee of surgery. I enjoyed him as an enthusiastic student, valued his help as house surgeon at the Bristol Royal Infirmary and later his professional comradeship. Whilst still a resident at Southmead Hospital he made his first contribution to the literature with a report of a rare case of epitheliomatous invasion

of the tibia from an overlying ulcer. He joined the Army in the early days of the war and was for a time stationed in the Orkney Isles. He went with the invading forces to Normandy and, when operating on casualties there, himself received a fatal wound. A sound clinician, he had a gently friendly way with patients and his life was one of unstinted service.

FREDERIC PERCIVAL MACKIE, C.S.I., O.B.E., M.D., M.Sc., D.P.H. (Bristol), F.R.C.S.

AN old Bristol student of very great distinction has recently passed away in Colonel F. P. Mackie. He was son of a late rector of Filton. Educated at Dean Close School, Cheltenham, Mackie entered the Bristol Medical School and University College in 1892, qualifying M.R.C.S., L.R.C.P., in 1897. He took his F.R.C.S. England in 1902, and after the University of Bristol was established he obtained the degrees of M.Sc. and M.D., as well as the D.P.H. in that University. In 1902 he entered the I.M.S., studying at Netley under Sir Almroth Wright, obtaining a Scholarship in Surgery, and following this with the Gold Medal in Medicine. He accompanied Younghusband on his expedition to Thibet. For the details of his subsequent career we are indebted to the *Lancet*.

On return in 1905 he became assistant director of the Plague Research Laboratory, Bombay, and was associated with the work of the Indian Plague Commission. There he made what was probably his chief contribution to medicine in the discovery, in 1907, of the transmission of relapsing fever by the body-louse—a discovery that led Nicolle to demonstrate a similar method of conveyance in typhus. In 1908, at the request of the Government of India, he was appointed a member of the Royal Society's sleeping-sickness commission and worked for over two years in Uganda and Kenya on trypanosomiasis and its connection with the indigenous fauna. From now on his name appeared in the publications with that of his chief, Sir David Bruce, Lady Bruce and his friend and colleague of the R.A.M.C., Colonel A. E. Hamerton. In 1911 he was employed in special research on kala-azar in Assam.

Thereafter Mackie saw active military service in Baluchistan and during the 1914–18 war in France and Mesopotamia, being mentioned twice in dispatches and receiving the O.B.E. Returning to India in 1920 he became, successively, director of the Pasteur Institute, Shillong, and in 1923 of the Haffkine Institute, Bombay. In 1928 he was appointed chairman of the plague committee of the League of Nations and officiating public health commissioner to the Government of India, later officiating surgeon-general with the Bombay Government. Just before he retired in 1932 he acted once more as director of the Research Laboratory in Shillong. At this time he published, with B. P. B. Naidu, an important paper on the serum therapy of plague (*Lancet*, 1931, ii, 893). Mackie was representative of the Government of India at the Office International d'Hygiène Publique at Paris in 1919, 1922,

1926, and 1930; president of the tropical diseases section at the centenary meeting of the British Medical Association in July, 1925, and president of the medical and veterinary section of the Indian Science Congress in 1925. In 1933 he joined the staff of the Hospital for Tropical Diseases in London as pathologist and he remained there for five years. During that time he published papers on the pathology of the brain in trypanosomiasis (1935), and with Hamilton Fairley a contribution on a peculiar streptothrical infection hitherto undescribed. In 1937 he surprised his friends by taking, despite his age, the appointment of chief medical officer of the British Overseas Airways Corporation. In this capacity he travelled thousands of miles from one end of Africa to the other, not apparently in any way affected by heat or fatigue, and was able to his great delight to view from the air herds of game in those vast wild regions where, as a young man, he hunted them on foot. His main interest in recent years was in the prevention of yellow fever on aerodromes in Africa, and research into the disinsectization of aircraft.

Mackie was twice married and had three sons, one by his first wife and two by his second wife who survives him.

FREDERICK JOHN POYNTON, M.D. (Lond.), F.R.C.P.

FREDERICK JOHN POYNTON was born at Kelston rectory, Bath, in 1869. On leaving Marlborough College he started his medical education at University College, Bristol, and continued it at St. Mary's Hospital where he won a scholarship in Anatomy and Physiology. He qualified in 1893, and rapidly showed the absorbing interest in children which largely determined his medical career. A disciple of Cheadle and Barlow, the two great figures in British Pædiatrics at the end of the last century, he was appointed to the staff of Great Ormond Street in 1900, and in 1903 became assistant physician to University College Hospital with charge of the Children's ward. He loved children and children loved him. In 1931, when President of the British Pædiatric Association, he said that "he who has brought a smile to the face of a dying child has had a glimpse of the eternal." Those who have been privileged to see Poynton handling a sick child will know that he must have had many such glimpses.

Poynton enjoyed teaching and his enthusiasm, frankness of speech and essential honesty of purpose endeared him to all students. Many of his old house physicians and registrars owe much of their later success in life to his tremendous inspiration and encouragement. The famous Saturday morning rounds at Great Ormond Street will never be forgotten by those who participated in them and, judging from the number of overseas visitors who attended, they must at one time have had an almost international fame.

His great work on the ætiology of acute rheumatism perhaps reached its climax in 1913 when he published in *Researches on Rheumatism* the collected results of fifteen years' work. His main thesis was that acute rheumatism is due to a streptococcus. This view has, of course,

been seriously attacked, but recent work has gone far to show that some such organism probably does play an important part in the production of the disease. Poynton never maintained, as his critics allege, that this organism was the only factor concerned. The acute controversy over this question has now largely died down and only time will show whether his view is correct or not. However, the most important and valuable part of his work was undoubtedly the interest and attention which he focussed on acute rheumatism. The realization of the importance of this disease in the causation of heart disease and our schemes for hospital schools and supervisory clinics are largely due to the work and enthusiasm of Poynton and his disciples.

His service to pædiatrics was recognized in 1930 by the award of the Dawson Williams Prize of the British Medical Association for *Advances in the Study of Children's Diseases in the British Empire.* He gave the Bradshaw Lecture at the Royal College of Physicians in 1924, and was Senior Censor in 1930. He was Lettsomian Lecturer in 1927, and Harben Lecturer in 1936.

Apart from his medical success Poynton achieved fame in quite another sphere. He played cricket for Somerset from 1891 to 1896 and hockey for Middlesex in 1894.

Poynton had associations with Bristol in addition to starting his medical studies here. In 1934 he gave the Long Fox Lecture on "Heart Disease in Childhood." He was consulting physician to Winford Orthopædic Hospital and always took a keen interest in the progress of the hospital. In the early days of his retirement to Bath he often motored over to see the cardiac patients.

Poynton, despite his long sojourn in London remained at heart a country man and was firmly attached to the West country. When the time came for him to retire from active practice he returned to the haunts of his childhood and settled in Bath. Here, after a narrow escape in an air-raid, he died of a heart attack on October 29th, 1943. His clinical enthusiasm and keenness persisted right to the end and only a few weeks before his death he published a stimulating and unorthodox paper on joint changes in acute anterior polio-myelitis, the result of observations made at the Bath and Wessex Orthopædic Hospital.

With his death we have lost one of the great men in medicine of the century.

FRANCIS WILFRED WILLWAY, M.D., M.S. (London), F.R.C.S.

BRISTOL suffered a great loss in the death of Wilfred Willway on 6th January. He came to the Bristol Royal Infirmary in 1936 as Surgical Registrar, after a brilliant career at King's College Hospital. He was the son of the late Dr. Frederick Willway of Streatham, and more distantly traced back to the Olive family, well-known in Bristol. His special surgical study was Neuro-Surgery, and as Professor Geoffrey Jefferson wrote in the *B.M.J.* (January 29, 1944): "We Neuro-Surgeons cannot afford these losses from our ranks." Much of his operative Neuro-Surgery was carried out at the Burden Neurological

Institute. But his Casualty Surgery at the Bristol Royal Infirmary in the air raids of 1940-41 called for uncommon skill and made tremendous demands on his strength. For through all that time he was an ailing man.

He knew that his years would be short; but he never flinched or stinted his efforts. To quote Jefferson again: "Few people realize that death is close upon them, and none that I have known have treated that knowledge with Willway's good-natured disdain."

Another colleague wrote of him in the *B.M.J.*:—

Wilfred Willway was one of the most brilliant students of King's College Hospital. He had that type of brain which makes its possessor able to play four games of chess and conduct a conversation at the same time. He never failed in any examination, took the F.R.C.S.Eng. and M.S.Lond. at an early age, and then the M.D. "just for fun," as he explained. He was a great teacher, whose students admired and loved him as did all his friends. As a man he was full of kindness and humility and yet charged with enthusiasm for his work and the welfare of his patients, students, and friends. Coming to Bristol from London, Willway entered fully into the teaching and professional work of the Bristol Hospitals and Medical School. He was a pillar of strength to the Hospitals' staff, who, because of his sound organizing powers, gave him charge of the war emergency arrangements at the Royal Infirmary. Willway was Bristol's first Neuro-Surgeon, and he was rapidly achieving a wide reputation for his work at the Infirmary and the Burden Neurological Institute. His courage was admirable, and in the course of a long day's operating it is reported that on one occasion he fainted twice. His tall spare frame, high forehead, and rather prematurely bald head, with merry eyes behind his large glasses, were the introduction to a personality which was widely loved and will be sadly missed. He was on a plane above most people, and Bristol is a poorer place for his departure.

The Annual Report of the Bristol Royal Hospital for 1943 pays him this tribute:—

Francis Wilfred Willway was appointed surgical Registrar in July, 1936, and temporary Honorary Assistant Surgeon in 1942. He possessed great organizing abilities and was made responsible for the reception of air-raid casualties, and for the admission and transfer of patients to E.M.S. Hospitals in this area. The arrangements made by him were carefully thought out and proved highly satisfactory.

He was Bristol's first Neuro-Surgeon and a leading authority in this country on the surgical treatment of mental disease. This was recognized by the Minister of Health who appointed him Deputy Regional Adviser on head injuries for the South West Region, shortly after the outbreak of war. The Royal College of Surgeons also recognized his abilities by electing him Hunterian Professor of Surgery in 1941. Mr. Willway was an outstanding personality who will be much missed.

A member of the permanent staff of the B.R.I. has written an appreciation from another angle, that of a non-medical fellow worker.

Of Francis Willway, Neuro-Surgeon, much has been written by

appreciative colleagues; it is of Francis Willway the man and leader of men, that I would write.

Probably few B.R.I. Medical Officers had made themselves as completely *au fait* with the whole working of the House and its departments before the war. Early in 1940, before the blitzes had begun, there was much anxiety among the various departments as to what would happen if and when German bombers arrived. No official lead had been given and no adequate preparations made. Willway, with his finger on many strings, sensed the uneasiness, and one day, long to be remembered, called a staff meeting at which representatives of all departments were present—Residents, Sisters, and Nurses, Almoners, Medical Students, Works departments, Pharmacists, etc., with Mr. Chitty in the chair. There he tersely sketched the position, and appealed to us all to play our part. Enthusiastically supported, he submitted a scheme for night and day vigilance, fireguards, stretcher-bearers, and their duties, which was agreed to by all present. Willway that very night saw the President, and obtained the official blessing on the programme, which has worked continuously and harmoniously until this very week, when C.D. precautions were relaxed by the Home Secretary. Willway not only originated the service, but played his part in it with conspicuous *élan*. In the early days before the blitzes began, and also when they were at their height, he was always on the spot with a kindly word for every one, a never failing sense of humour, and the highest ideal of duty.

Few of us will forget him in that crowded O.P. department, sorting the cases, and getting them away without fuss to their wards. And the thing he started lived and grew, and from that day there was system and organization for the B.R.I. civil defence. To Francis Willway the B.R.I. owes it all. He was the Leader. "Ave atque vale."

As we go to press we learn with great regret of the death of Emeritus Professor E. W. Hey Groves, LL.D., D.Sc., M.S., F.R.C.S. A memoir of him will be published in our next issue. R.I.P.

The Medical Library of the University of Bristol

WITH WHICH IS INCORPORATED

The Library of the Bristol Medico-Chirurgical Society

The following donations have been received since the publication of the list in the last issue.

Dr. Helen Aldwinckle (1)	Two volumes.
Sir Stanley Badock (2)	One ,,
British Journal of Surgery (3)	One ,,
General Medical Council (4)	Two ,,
Henry Phipps Institute (5)	One ,,
Michell Clarke Bequest (6)	Eleven ,,
Munro Smith Fund (7)	Two ,,
Royal College of Physicians (8)	One ,,
J. E. Shaw Fund (9)	Five ,,
University of Otago (10)	One ,,
John Wright & Sons Ltd. (11)	Two ,,

Unbound periodicals have also been received from Dr. S. B. Adams, Captain Walter Goldfarb (U.S. Medical Corps), Professor E. W. Hey Groves, Dr. T. Milling, Professor C. Bruce Perry, Dr. J. Odery Symes, Messrs. John Wright & Sons Ltd.

THE ONE HUNDRED AND SEVENTY-EIGHTH LIST OF BOOKS.

The figures in round brackets refer to the figures after the names of the donors. The books to which no such figures have been attached have either been bought from the Library Fund or received through the *Journal*.

Alyea, O. E. van ..	*Nasal Sinuses*	(3)	1942
Barzilai, G.	*Atlas of Ovarian Tumours*	(6)	1943
Berkeley, G. H., and Bonney, V.	*Textbook of Gynæcological Surgery* 4th Ed.	(6)	1942
Bernier, J. L.	*A Manual for the Differential Diagnosis of Oral Lesions*		1943
Biologists in Search of Material		(1)	1938
Bomfin, R. da C. ..	*Tratamento das fraturas da coluna vertebral* ..		1942
British Pharmacopoeia		6th Addendum	1943
Burnet, J.	*Outlines of Industrial Medicine, Legislation and Hygiene*		1943

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British Pharmacopoeia .. .. 6th Addendum 1943
Burnet, J. .. .. .. *Outlines of Industrial Medicine, Legislation and Hygiene* 1943

Cellona Technique .. .. 5th Ed. 1939

Chamberlain, E. Noble *Symptoms and Signs in Clinical Medicine* 3rd Ed. 1943

Chapman, H. E. .. .. *The Law Relating to the Marketing and Sale of Medicines* 1942

Chronic Pulmonary Disease in South Wales Coalminers. II. Environmental Studies. (M.R.C. Special Report Series, 244.) 1943

Clark, A. J. .. .. .. *Applied Pharmacology* .. .. 7th Ed. (6) 1942

Comroe, B. I., and others *Internal Medicine in Dental Practice* 2nd Ed. 1942

Crile, G., and Shively, F. L. *The Hospital Care of the Surgical Patient* (11) 1943

Curran, D., and Guttman, E. *Psychological Medicine* 1944

Diseases of the Basal Ganglia. (Association for Research in Nervous and Mental Diseases) 1942

Garrison, F. H., and Morton, L. R. *A Medical Bibliography* 1943

Gibbens, J. H. .. .. *The Care of Young Babies* .. .. (6) 1943

Gregg, A. L. .. .. *Tropical Nursing* .. .. 2nd Ed. 1943

Guirdham, A. .. .. *Disease and the Social System* 1942

Hill, A. B. .. .. .. *Principles of Medical Statistics* .. .. 3rd Ed.

Ilgenfritz, H. C., and Penick, R. M. *Synopsis of the Preparation and Aftercare of Surgical Patients* 1942

Index to the Manual of the International List of Causes of Death (5th rev., 1938) 1944

Jones, H. W., and Chamberlain, E. N. *Electrocardiograms* .. .. 2nd Ed. 1943

Langdale-Kelham, R. D., and Perkins, G. *Amputations and Artificial Limbs* 1942

Lundy, J. S. .. .. *Clinical Anæsthesia* .. .. (6) 1943

MacBride, W. C., and others *Juvenile Dentistry* .. .. 3rd Ed. 1941

Macgregor, A. Lee .. *Synopsis of Surgical Anatomy* .. .. 5th Ed. 1943

MacMurray, T. P. .. *A Practice of Orthopædic Surgery* 2nd Ed. (6) 1944

Maingot, R. H., and others [Ed.] *War Wounds and Injuries* 2nd Ed. (6) 1944

Meek, T. H. .. .. *Guide to First-Aid Treatment of Home Guard Casualties* 1943

Mellanby, K. .. .. .. *Scabies* 1943

Newman, G. .. .. .. *The Building of a Nation's Health* 1939

Osborne, J. .. .. .. *Acrylic Resins in Dentistry* 1944

Pearse, I. H., and Crocker, L. H. *The Peckham Experiment* .. .. (1) 1944

Pemberton, R., and Osgood, R. B. *Medical and Orthopædic Management of Chronic Arthritis* .. .. (2) 1934

Peters, J. P., and others *Problems of Intestinal Obstruction* 1941

Pickles, W. N. .. .. *Epidemiology in a Country Practice* 1939

Pohl, J. F., and Kenny, E. *Kenny Concept of Infantile Paralysis* .. (11) 1943

Price, D. S. .. .. .. *Tuberculosis in Childhood* 1942

Provisional Classification of Diseases and Injuries for use in Compiling Morbidity Statistics by the Committee on Hospital Morbidity Statics. (M.R.C. Special Report Series, 248.) 1944

Roberts, C. S. L., and others *Sterility and Impaired Fertility* 1939

Roesler, H. .. .. .. *Clinical Roentgenology of the Cardiovascular System* 2nd Ed. 1943

Rolleston, H. D. [Ed.] .. *British Encyclopædia of Medical Practice* :—

Medical Progress .. .. (9) 1944

Cumulative Supp. .. .. (9) 1944

Rolleston, H. D. .. .. *A History of "The Practitioner,"* 1868-1943 .. 1943

Rolleston, H. D., and Moncrieff, A. A. [Eds.] *Minor Surgery* .. .. (6) 1943

Royal College of Physicians of London—Planning Committee—Report on Medical Education .. .. (8) 1944

Raven, R. W.	*The Treatment of Shock*		1942
Shaw, W.	*Textbook of Midwifery*	(6)	1943
Smart, J.	*Handbook for the Identification of Insects of Medical Importance*		1943
Smout, C. F. V.	*The Anatomy of the Female Pelvis*	(7)	1943
Snapper, I.	*Medical Clinics on Bone Diseases*	(9)	1943
Solomons, B.	*A Handbook of Gynæcology* 3rd Ed.	(6)	1934
Stitt, E. R., and others	*Practical Bacteriology, Hæmatology and Animal Parasitology* 9th Ed.		1943
Ten Chapters on the Bath			1829
Thoma, K. H.	*Traumatic Surgery of the Jaws*		1942
Tidy, N. M.	*Massage and Remedial Exercises in Medical and Surgical Operations* 6th Ed.		1944
Treves, F.	*Student's Handbook of Surgical Operations* 7th Ed.		1943
Turner, G. Grey [Ed.]	*Modern Operative Surgery*, 3rd Ed., 2 vols.	(7)	1943
Winter, L.	*Operative Oral Surgery* 2nd Ed.	(6)	1943
Wintrobe, M. M.	*Clinical Hæmatology*		1942
Zilboorg, G., and Henry, G. W.	*A History of Medical Psychology*		1941

TRANSACTIONS, REPORTS, JOURNALS, ETC.

Annual Report of the Smithsonian Institution (for year ending 1899)		1942
British Encyclopaedia of Medical Practice :—		
Cumulative Supp., 1943 and 1944	(9)	
Medical Progress, 1944	(9)	
Dentists' Register, 1944	(4)	
Medical Directory, 1944		
Medical Register, 1944	(4)	
Proceedings of the University of Otago Medical School, Number 21, 1944	(10)	
Quarterly Cumulative Index Medicus, Volume 34 (July-Dec., 1943)		
Report (28th) of the Henry Phipps Institute, 1938-39	(5)	
Year Book of Radiology, 1943		

Publications Received

From ASTHMA RESEARCH COUNCIL :

Physical Exercises for Asthma. Fourth Edition. 1943. Price 1s.

From MESSRS. HODDER AND STOUGHTON :

Care of Tuberculosis in the Home. By JAMES MAXWELL. Price 7s. 6d. 1943.

Endocrine Disorders in Childhood and Adolescence. By L. LE MERGUARD and H. TOZER. 1943. Price 15s.

From MESSRS. H. K. LEWIS & CO. LTD. :

Common Skin Diseases. By A. C. ROXBOROUGH, M.D. Seventh Edition. 1944. Price 18s.

Caesarean Section. By J. H. YOUNG. 1944. Price 6s.

Guide to the Surgical Paper. By R. J. MCNEILL LOVE, F.R.C.S. Second Edition. 1944. Price 6s.

From THE PRACTITIONER LTD.:

History of "The Practitioner." 1868–1943.

From the OXFORD UNIVERSITY PRESS:

Notes for the R.M.O. of an Infantry Unit. By G. P. BLACKER (Oxford War Manuals). 1944. Price 5s.

Elementary Morphology and Physiology for Medical Students. By J. H. WOODGER. Third Edition. 1943. Price 15s.

From MESSRS. JOHN WRIGHT & SONS LTD.:

British Journal of Surgery. General Index, 1934–43. Price 21s.

British Journal of Surgery. Numbers 123, 124. 1944. Price 12s. 6d. each.

Physical Signs in Clinical Surgery. By HAMILTON BAILEY, F.R.C.S. Ninth Edition. 1944. Price 25s.

Local Medical Notes

Professor C. M. Yonge, D.Sc., has been appointed Regius Professor of Zoology in the University of Glasgow.

EXAMINATION RESULTS.

Students of the University have recently passed the following examinations:—

University of Bristol.—M.D.—G. H. Tovey, with Distinction.

CH.M.—Marjorie O. Dunster.

M.B., CH.B.—*First Examination:* Evelyn R. Brooks, Diana F. J. Duncan, Joan A. Higginbottom, C. D. Linton, Elizabeth Preston-Thomas, Gloria M. Rhodes, J. A. Beel, A. R. Ebanks, P. C. Farrant, Katharine, E. Fawcus, Pamela Hawkins, Pamela M. Hellings, Hilary M. K. Jenkins, G. Lucas, Ellen M. Marron, Elizabeth M. Morgan, P. A. Normandale, A. Ressel, Lucie Rosenhaugh, Margaret R. Salisbury, G. Waters, Stephanie Wright. *In Organic Chemistry:* Molly I. Govier, G. T. Salter, Naldo Sartori, H. Schnieden. *In Physics:* I. L. Brander,† D. M. Gambier.† *In Chemistry:* F. V. Eastman.† *In Biology:* Patricia M. Gilbert,† H. Schneiden.†

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